NC DIVISION MH/DD/SAS
2009 TARGETED CASE MANAGEMENT AUDIT

PROVIDER NAME:		**AUDIT DATE:**	
ATTENDING PROVIDER #:		**NAME:**	
CONTROL #:		**SERVICE TYPE:**	
MEDICAID #:		**PROCEDURE CODE:**	
DOB/AGE:		**SERVICE DATE:**	
RECORD #:		**UNITS PAID:**	

RATING CODES:	O = No 2 = partially met 4 = Yes	6 = No service note 7 = Unable to identify service provider	8 = Repaid 9 = NA	**RATING**
AUTHORIZATIONS/SERVICE PLAN (Use rating of "4", "0" or "9" for Q 1-3)				
1. a. Is an authorization in place covering this date of service? b. If NO, list dates: FROM_____ TO_____				
2. a. Is there a valid service order for the service billed? b. If NO, list dates: FROM_____ TO_____				
3. a. Is the date of service covered by a valid Service Plan? b. If NO, list dates: FROM_____ TO_____				
SERVICE DOCUMENTATION (Use Likert Scale See Instructions): **(Use rating of "4", "2" or "0" for Q 4-9 and "4" or "0" for Q10—or ratings of 6, 8, or 9 as applicable)**				
4. Is the Service Plan individualized per person?				
5. Is the documentation signed within the designated time frame by the person who delivered the service?				
6. Does the service note(s) relate to goals listed in the Service Plan?				
7. Does the documentation reflect treatment for the duration of service?				
8. Does the service note reflect assessment of progress toward goals?				
9. Are the service notes individualized per person?				
10. Do the units documented match units paid? If no write units documented: _____				
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 11-14—or ratings of 6, 8 or 9 as applicable)				
11. a. Is there documentation that the staff is qualified to provide the service billed? b. If NO, list dates: FROM:_____ TO:_____				
12. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service? b. If NO, list dates: FROM:_____ TO:_____				
13. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? b. If NO, list dates: FROM:_____ TO:_____				
COMMENTS:				
AUDITOR:		**BILLING LME:**		